# Application for Discounted Services

***Proof of income is required prior to receiving discounted services. Include income for everyone in the household over the age of 18.***

First Name: _____ Last Name: _____ Middle: Date of Birth: _____/_____/_____

How many people live in your household?_____

Do you split bills? (rent/utilities) YES NO

Do have proof of income with you today? YES NO

Do you have insurance? YES NO

Are you currently employed? YES NO

If employed, answer the below questions:

What is your hourly rate? _____

How many hours worked in a week? _____

Name of employer? _____

| List All Member of Household | Relationship to the Patient | | | | | Currently Employed | | If Employed | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Last Name, First Name | spouse | child | parent | friend | other | YES | NO | Hours worked per week | Hourly rate of pay | Employer Name |
| *Mouse, Mickey* | *X* | | | | | *X* | | *40* | *$12.00* | *Disney Company* |
| | | | | | | | | | $ | |
| | | | | | | | | | $ | |
| | | | | | | | | | $ | |
| | | | | | | | | | $ | |
| | | | | | | | | | $ | |
| | | | | | | | | | $ | |

**Do you or does anyone in the household receive any of the following? If yes, please fill in the total amount received before taxes or deductions.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Alimony | YES | NO | $ _____ | Pension | YES | NO | $ _____ |
| Cash Support from friends or family | YES | NO | $ _____ | Social Security (SSI or SSD) | YES | NO | $ _____ |
| Child Support | YES | NO | $ _____ | SRS Income | YES | NO | $ _____ |
| Food Stamps | YES | NO | $ _____ | Unemployment | YES | NO | $ _____ |
| Other | YES | NO | $ _____ | Worker's Compensation | YES | NO | $ _____ |

By signing below, I state that the above financial information is correct. I agree to provide all financial information on a yearly basis in order to qualify for discounted services. I agree to notify Atchison Community Health Clinic immediately if my financial situation changes during the year. I understand that if Atchison Community Health Clinic finds that I have intentionally given false information, I will immediately forfeit my rights to discounted services.

Signature: _____ Date: _____

Office Use Only: Initials: _____ Family Size: _____ Total Yearly Income: $_____ POI: YES NO

Notes: _____

Slide Assigned: _____SLIDE A - $15.00 _____SLIDE B - $25.00 _____SLIDE C - $35.00 _____ SLIDE D - $45.00 _____SLIDE E - Full Fee